A CASE OF CHOLECYSTOTOMY FOR GALL-STONES.

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THE operation of cholecystotomy has, of late, become quite a common operation in Europe; in America, however, but few cases have been reported. The operation was first described over 150 years ago by Petit. It was forgotten until Marion Sims, in Paris, in 1878 revived it. The result in his case was fatal.

In 1879 Mr. Lawson Tait successfully performed the operation on a woman, æt. 40 years, and since that time it has been frequently performed with satisfactory results. Mr. Tait[1] has performed cholecystotomy some 55 times, with 3 deaths, 2 of which were due to cancer of the liver.

The difficulties of the operation vary greatly in different cases. When the gall-bladder is distended, its wall can be sutured to the abdominal parietes, then incised, and the gall-stones extracted; but when the gall-bladder is shrunken and small, or altered by inflammatory action, the operation of cholecystotomy may present unusual difficulties.

The operation of cholecystotomy, or removal of the gall-bladder, is advocated by some surgeons (e. g., Langenbuch, of Berlin, and Knowsley Thornton, of London) as preferable to cholecystotomy. The operation is a much more serious one, and the results obtained are no better than in cholecystotomy. The one point in its favor is that it prevents a recurrence of the conditions which necessitated the operation, but on the other hand in many cases, owing to changes produced by imflammatory action, it is impracticable and it will not relieve an obstruct-

[1]Edinburgh Medical Journal Oct. and Nov., 1889.

ed common duct. No doubt in some cases cholecystectomy is advisable, whilst in others, which form the majority, cholecystotomy should be practiced. More evidence is neccessary before exact rules can be laid down as to the choice of operation.

The diagnosis of gall-stones in some cases is very easy, whilst in others most difficult. The case I am about to relate, comes under the latter category, for it was thought to be a case of malignant disease until the abdomen was opened and a close investigation of the tumor showed it to be a very much altered gall-bladder enclosing three large stones. Without further preliminary remarks I shall now give a report of the case:

Mrs. B. æt 51 years, was sent me by Dr. Lynch of Winnepeg, Man., in June last, suffering from a tumor of the abdomen which he thought might be relieved by operation. She is a fairly well-nourished woman, of rather blonde complexion, mother of eight children. Has lived in India and has always enjoyed good health up to a year ago. When on a visit to England in 1889, she was first troubled with dyspeptic symptoms, discomfort after eating, and pain in the epigastrium. During the past year has been losing flesh and recently has rapidly become thinner. Six weeks before consulting me she was suddenly seized with a severe pain in the epigastrium accompanied by incessant vomiting and great tenderness over the abdomen with elevation of temperature. Dr. Lynch at this time first detected a tumor to the right of the umbilicus about as large as an orange, which was tender and quite movable. Since the first attack she has had two others precisely similar and has never been free from pain and discomfort about the abdomen especially after eating or moving about much. Owing to the severe continuous pain she has been more or less under the influence of morphia for the last six weeks. Has never had jaundice. I saw her on June 13, 1890, for the first time with Dr. George Ross and Dr. A. A. Browne. On examining the abdomen we easily made out a tumor apparently about the size of a fœtal head to the right and overlapping the median line below the umbilicus. The tumor was smooth on the surface and deeper down appeared to consist of a hard irregular mass. It was freely movable but was most easily pushed upwards and to the left; dull on percussion and tender to the touch. Temperature and pulse normal. We all came to the conclusion that we had to do with a malignant growth connected with the pyloric end of the stomach or even

probably with the bowel. We decided to recommend an exploratory incision and were prepared to remove it if possible.

Operation June 17, 1890. Assisted by Dr. James Bell I opened the abdomen in the median lime immediately over the tumor at the level of the umbilicus. On opening the peritoneal cavity an elongated portion of the liver was first met with and this was the smooth surface of the tumor which had been previously felt. Beneath this portion of the liver was a large hard mass covered by omentum and intestine. The mass felt hard and nodular like a new growth and was almost the size of a base-ball. The liver appeared to be cirrhotic and although attached to the tumor was not

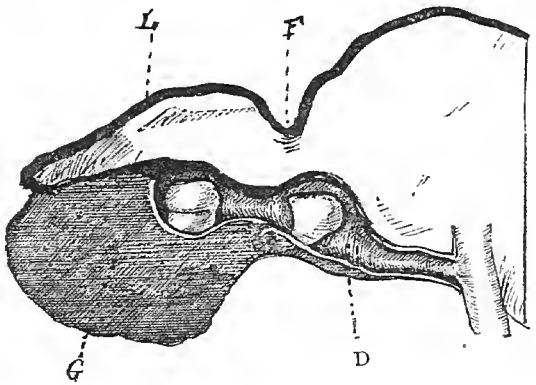

FIG. 1.—SKETCH OF SUPPOSED CONDITION OF GALL-BLADDER.

G. Thickened gall-bladder containing gall-stones. D. Cystic-duct dilated and containing gall-stone. L. Lacing lobe. F. Lacing furrow.

infiltrated by it. After carefully examining the parts I looked for the gall-bladder but failed to find it, so the mass beneath the liver was still further investigated by lifting up the lobe of the liver covering it. The adhesions were easily torn through and some bleeding took place. Whilst separating the parts there was a gush of dark colored fluid and putting my fingers in the opening from where the fluid flowed I came upon a hard substance which I extracted with a pair of forceps. This proved to be two large gall-stones fused together and about the size of small wallnuts. Pushing my fingers still further into the cavity I felt a narrow orifice and behind this another cavity containing a large stone. This was extracted with difficulty by pushing it from behind by means of the fingers of the other hand passed beneath the liver.

No other stones could be felt in the direction of the common duct. The tumor bore not the slightest resemblance to a gall-bladder and looked more like a mass of new growth or inflammatory tissue in which were inbedded the stones and over which was liver and intestines. During these manipulations the peritoneal cavity had been guarded by sponges so no fluid escaped into it. The parts where irrigated by hot water and now the problem was how to attach this very much altered gall-bladder to the abdominal wall and to prevent escape of bile into the peritoneal cavity. The edges of the cavity which had contained the gall-stones were so friable that they could not be brought up to the abdominal wall. However, with a continous silk suture, omentum was made use of in some places and portions of liver in others to fill in the space which existed between the wall of the abdomen and the edge of the altered gall-bladder, and at last with much difficulty the task was accomplished.

A red rubber drainage tube was introduced into the cavity past the constricted portion; over this was replaced the portion of liver which had been lifted up and then the abdominal incision was closed with half a dozen silkworm gut sutures, the drainage-tube protruding from the rear end of the wound. The wound was dressed with washed gauze and a pad of absorbent cotton. The patient rallied well from the operation, which had taken some time, and had no vomiting. There was some thirst and pain complained of the first 24 hours. The temperature was normal throughout and pulse never rose above 90.

Next morning, owing to the great discharge of bile, the dressing had to be changed and after this twice daily, the dressing being saturated with bile, immense quantities of which escaped. On the third day the tube was shortened, and on the fifth day the stitches and tube were removed and the wound was found completely healed except where the tube had been.

On the 9th day patient was up and dressed and moving about the room. The bile still continued to flow in large quantities at night only when on her side. Bowels were kept freely opened by salines and the stools although light-colored were not white. At the end of the second week the patient said she felt as well as ever she did and went out driving every day. The bile ceased to flow quite suddenly on the 15th day after operation. The sinus having completely healed up, a careful examination was made and no tumor could be felt nor was there any tenderness. She left for home on July 11, feeling perfectly well.

I have given this case in detail chiefly on account of the great difficulties there were in diagnosis. The case was a puzzling one even after the abdonen was opened, the gall-bladder being so altered as not to be easily recognizable. It was composed of a large mass of tissue the character of which could not with certainty be made out. To the naked eye it might have been new growth or inflammatory tissue. Portions of this tissue were removed and examined microscopically by Dr. W. Johnston, pathologist to McGill University, and pronounced by him to be composed entirely of inflammatory tissue. The elongated portion of the liver, above referred to, seemed to be entirely bloodless when cut into, in fact it was in a condition of cirrhosis, due no doubt to long continued pressure of the borders of the ribs on the right lobe of the liver from tight lacing, what has been called by Marchand a true lacing lobe being formed; the gall-bladder being entirely in this part of the right lobe the thinned portion of the liver is directly over the neck of the gall-bladder and cystic duct; this produces stagnation of the flow of bile and leads to its thickening and the formation of the gall-stones. My patient asserted she had never laced tightly. Still some pressure must have been exercised to cause the condition of liver found. The result of this case was most encouraging and points to the advantage of exploratory laparotomy in doubtful and even apparently hopeless cases.